Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS INJURY CLINIC
2121 N MAIN
FORT WORTH TX 76134

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
EMPLOYERS ASSURANCE CO

Carrier's Austin Representative Box
Box Number 34

MFDR Tracking Number
M4-09-6679-01

MFDR Date Received
MARCH 6, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After calling to clarify the second denial, we were told a required 'GP' modifier was missing from the codes submitted for reimbursement. We have researched this matter extensively and disagree with the rationale for denial."

Amount in Dispute: $889.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is this Carrier's position that the requestor did not submit billing with the required modifier –GP, therefore, no reimbursement is due."

Response Submitted by: UniMed Direct, 5068 W. Plano Pkwy, Suite 122, Plano, TX 75093

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2008 – March 7, 2008	Physical Therapy Services CPT Codes G0283, 97140, 97110, 97035, 97024, and 97112	$889.27	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Reimbursement is made based on Medicare coding, billing and reimbursement methodologies.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the requestor attach the correct modifier in accordance with Medicare coding?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied payment alleging that the physical therapy codes billed by the requestor did not contain a proper modifier. 28 Texas Administrative Code §134.203 (b) (1) states, in pertinent part, that "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing;…in effect on the date a service is provided with any additions or exceptions in the rules." Section 134.203(a)(5) defines "Medicare payment policy" to mean reimbursement methodologies, models, and values weights including its coding, billing and reporting payment policies as set forth in the Centers for Medicare and Medicaid services (CMS) payment policies specific to Medicare. According to the Medicare Part B Physical Therapy Manual the CPT Codes billed by the requestor are "always therapy" services regardless of who performs them. These codes always require therapy modifiers GP, GP, or GN.
2. Review of the submitted documentation finds that the requestor did not attach the proper modifier when billing the physical therapy codes; therefore, reimbursement is not warranted.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 3, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.